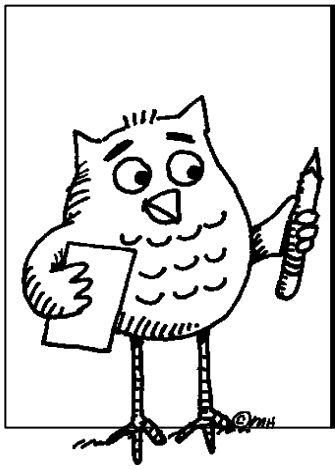

Waiver Wise

Technical Assistance for the Community Options Program Waiver COP-W

Wisconsin Department of Health & Family Services • Division of Supportive Living
Bureau of Aging & Long Term Care Resources

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Medicaid Denials

The purpose of this technical assistance document is to give information and options to care managers when they are presented with a Medicaid denial for an item, supply or service.

As stated in the Medicaid Waivers Manual (Chapter I, 1.09), "MA services available through the participant's MA card (with the exception of care management services only) must be accessed before using waiver funds." Below are three reasons why it's important to access Medicaid to pay for an item, supply or service.

1) The Federal Department of Health and Human Services's State Medicaid Manual (SMM) 4442.3A 3. requires that "No services may be provided under the waiver if it is already provided under the state plan unless the nature or amount of the service, when provided under the waiver, would not be covered if provided under the state plan." That regulation also states "The amount chargeable for waiver services is that amount incurred after any limits in State Plan services have been reached."

2) It helps the county because it "stretches" their waiver allocation. By using Medicaid funds to pay for needed items/supplies or services, it enables counties to use their waiver allocation for services that are not allowable under Medicaid. In addition, more waiver program funds available means more people can receive assistance.

3) It helps participants because currently Durable Medical Equipment (DME) and Durable Medical Supplies (DMS) acquired with Medicaid funds are not subject to estate recovery. This may ease the mind of participants who are concerned about estate recovery. FYI: if waiver funds are used to pay for a DME, DMS, or service, it is subject to estate recovery.

In order for Medicaid to pay for an item or supply, it is important to remember that some Medicaid services require approval, known as Prior Authorization (PA) by Wisconsin Medicaid before the provider supplies the item or performs the service. All PA requests are reviewed for medical necessity and consistency with the diagnosis/clinical condition of the participant.

The usual procedure that is followed when an adaptive aid, communication device, medical supply or service, such as personal care is needed, is that either the care manager or in some cases, the participant themselves, will discuss the need with the participant's physician. The physician then writes a prescription or "order" for the item or service and this information is presented to a Medicaid certified provider. When Medicaid requires prior authorization for the service, the provider then submits the appropriate paperwork to Medicaid's fiscal intermediary, EDS to obtain Prior Authorization. The information submitted for the prior authorization is reviewed by EDS staff and if necessary in the Department of Health and Family Services - in the Division of Health Care Financing (DHCF).

Once the prior authorization request is submitted, there are four options available to DHCF when considering the item, supply or service. The request for the Medicaid funded item or service can be:

1) Approved
2) Denied
3) Modified, or
4) Returned to a provider for more information, usually because the provider did not include sufficient documentation of the need for the service.)

FYI: if a request is modified it means what was originally requested was not approved but, that a lesser amount or time has been approved. For example: an original order may have requested weekly nursing visits to set up a pill box, but the modified approval was for nursing visits every other week. Another example: 100 incontinence pads were originally requested, but the modified approval was for 70 pads.

It is important for vendors to fill out all PA Requests completely and thoroughly. The information listed regarding the item needed and the specifics regarding the participant's medical diagnosis and/or disability, and the need for the service for a particular individual the key for reviewers at DHCF to make appropriate decisions.

Waiver program funds can only be used if:

a) The item or supply has been denied, or

b) The original request has been modified and the remaining portion of the request not fundable by Medicaid is still needed for the health and safety of the recipient in the community. Waiver funds can pay for the supplies/items not authorized by Medicaid. This does not include provider charges above the Medicaid's reimbursement. See 42 CFR (Code of Federal Regulation) subsection 447.20 for more information.

If an item, supply or service is denied or modified by Wisconsin Medicaid, <u>both</u> the provider and the participant are notified. The provider receives the denied or modified PA Request form from the Medicaid fiscal agent, EDS. The participant receives a letter explaining that the PA Request was denied or modified and information on his/her right to a fair hearing.

Although providers cannot appeal, if a provider disagrees with the decision to either deny or modify the PA Request, they have a couple of options. If the request was *modified,* the provider can submit an amendment request with additional documentation

that supports the original PA Request. Important note: the amendment request must be received within two weeks of the date the original PA Request was signed by the consultant. If the PA Request was *denied*, the provider can submit a new PA Request with additional clarifying information for reconsideration.

If a participant wishes to appeal a denial or modification to a PA Request, they may do so by requesting a fair hearing. As mentioned earlier, participants receive a written letter informing them whether the item or supply was denied or modified. In that letter, information is relayed on how to appeal the decision. The participant must request the fair hearing by the appeal date indicated in the letter, although providers may help in this process. A request for a fair hearing is made to the local county or tribal social/human services agency in the participant's county of residence**, or**, to the Division of Hearing and Appeals. FYI: hearings are held in the participant's county of residence.

It is not a requirement that the participant appeal a written denial or modified approval before waiver program funds will pay for the item or supply, although appeals are encouraged when the item or supply is medically necessary.

Commonly Asked Questions

Question 1 – How can a care manager document within the case file that an item or supply has been formally denied?

Remember, both the provider and the participant receive a written notice indicating if the request was either denied or modified. The care manager can either make a copy of this information and place it in the participant's file, or the care manager can see the denial at the participant's home and make a case note within the participant's file that this documentation was viewed and is available.

Question 2 – Does a Medicaid certified provider have a right to refuse to provide a service?

Yes.

Question 3 – What should a care manager do if a Medicaid certified provider refuses to request prior authorization for equipment, supplies or services because the provider is not satisfied with the Medicaid reimbursement rate?

As we know, for most services and items, Wisconsin Medicaid reimburses providers the lesser of the billed amount or the maximum allowable fee established by the Department of Health and Family Services (DHFS). These amounts established by the DHFS are published in fee schedules, and are available to all providers and other interested parties.

BALTCR is aware that some providers have taken the position of not requesting prior authorization because they feel Medicaid's reimbursement rate is too low. Because it is important to maximize Medicaid dollars, care managers should locate a provider who will accept the Medicaid reimbursement rate. This may mean the care manager will be going out of their immediate area or local community to locate a provider. That is why it is important for care managers to become familiar with as many Medicaid certified providers as they can in their area.

Question 4 – If a vendor refuses to request prior authorization for an item or supply because they are unsatisfied with the Medicaid reimbursement rate, can a care manager consider that a "denial by a MA provider" and use waiver program funds to pay for the item in full?

No. A denial has not been received from Wisconsin Medicaid. Rather, what has occurred is that a provider has refused to provide a service. It is important for care managers to work with providers who are willing to accept the Medicaid reimbursement rate.

Question 5 – What if there are a limited number of providers in my area?

If you cannot locate a provider in your area or local community, care managers are encouraged to look outside your local community. However, if after making a reasonable effort to find a Medicaid-certified provider, but there is no willing provider for an item or supply, and when the item or supply is important to the health and safety of the participant, non-waiver program funds can be considered. Please keep in mind, if COP funds are being used to pay for a service that Medicaid generally covers, this information will be referred to BALTCR for follow up.

In addition, if vendors are not available locally the care manager can ask the participant's physician to recommend an alternative service, item, etc. that will meet the participant's specified need. Note: this does not apply to providers of professional services (i.e., dentists).

Question 6 – What recourse do care managers have when they are aware that a provider is not honoring their function as a certified Medicaid provider?

Care managers can contact a number of people to help deal with the situation. Their regional Medicaid Professional Relationship Representative can be a good person to contact to see if the Representative can assist the provider in any way. (See attached listing). Another excellent source of advocacy for participants is the local Benefit Specialists in the county. Finally, care managers can empower the participant by having the participant call or write a Division of Health Care Financing representative that a Medicaid provider is not assisting them.

Question 7 – What do I do if I know Medicaid never funds specific Durable Medical Equipment (DME) or Durable Medical Supplies (DMS)? Do I still have to make a vendor request prior authorization simply to get a Medicaid denial?

No. BALTCR recognizes that there are many routine items that Medicaid does not cover. However, it is still important to document within the case file that Medicaid funds do not cover these items or services. The care manager can document by means of a case note that Medicaid will not cover the item or services. Information on Medicaid service coverage may be found in the Medicaid Providers Handbooks and Updates. These may be obtained on the Internet at *www.dhfs.state.wi.us/medicaid/*. A free copy is also provided to each Medicaid provider. In addition, Wisconsin Administrative Code, which outlines coverage, requirements and limitations for all Medicaid services, is available in Wisconsin Administrative Code, Chs. HFS 101-108. See in particular: Ch. 101.03 (96m)

‘medically necessary” and Chs. 105 and 107. This document is available at *www.legis.state.wi.us/rsb/code*.

Counties may wish to use the attached tool that was developed to help meet this requirement. (See attached sheet.) This tool can be placed in the participant’s file and each time an item or supply is provided, the care manager can check off the appropriate information. This tool is not an all-inclusive list and counties may wish to include additional items or develop their own form to meet this requirement. In the event of a Federal review, this form can easily be located.